FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040436

Facility Name: STERLING PAVILION, LTD.

Address: 105 E. 23RD STREET (Number) STERLING (City) 61081 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 626-4264 **Fax #** (815) 626-3254

IDPA ID Number: 363873072001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,613	4,370	2,218	10,201	8
9	SNF/PED					9
10	ICF	21,479	5,942	85	27,506	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,092	10,312	2,303	37,707	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.38%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2181

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	147,391	10,479	8,080	165,950		165,950		165,950			1
2	Food Purchase		153,497		153,497		153,497	(1,067)	152,430			2
3	Housekeeping	106,917	19,576		126,493		126,493		126,493			3
4	Laundry	50,184	21,623		71,807		71,807		71,807			4
5	Heat and Other Utilities			118,674	118,674		118,674	691	119,365			5
6	Maintenance	49,655	54,856	28,144	132,655		132,655	5,200	137,855			6
7	Other (specify):*							1,052	1,052			7
8	**TOTAL General Services**	354,147	260,031	154,898	769,076		769,076	5,876	774,952			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,255,982	64,731	16,515	1,337,228		1,337,228	(331)	1,336,897			10
10a	Therapy	83,635		16,020	99,655		99,655		99,655			10a
11	Activities	55,336	2,310		57,646		57,646		57,646			11
12	Social Services	39,448		5,315	44,763		44,763		44,763			12
13	Nurse Aide Training			1,740	1,740		1,740	108	1,848			13
14	Program Transportation			76	76		76		76			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,434,401	67,041	39,666	1,541,108		1,541,108	(223)	1,540,885			16
	C. General Administration											
17	Administrative	74,400			74,400		74,400	130,618	205,018			17
18	Directors Fees											18
19	Professional Services			224,222	224,222		224,222	(188,205)	36,017			19
20	Dues, Fees, Subscriptions & Promotions			30,605	30,605		30,605	(24,006)	6,599			20
21	Clerical & General Office Expenses	38,914	5,170	29,222	73,306		73,306	39,971	113,277			21
22	Employee Benefits & Payroll Taxes			331,394	331,394		331,394	(18,560)	312,834			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,192	1,192		1,192	771	1,963			24
25	Other Admin. Staff Transportation			748	748		748	58	806			25
26	Insurance-Prop.Liab.Malpractice			96,439	96,439		96,439	3,114	99,553			26
27	Other (specify):*							21,025	21,025			27
28	**TOTAL General Administration**	113,314	5,170	713,822	832,306		832,306	(35,214)	797,092			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,901,862	332,242	908,386	3,142,490		3,142,490	(29,561)	3,112,929			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number STERLING PAVILION, LTD. #0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,039	59,039		59,039	190,836	249,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,036	31,036		31,036	657,706	688,742			32
33	Real Estate Taxes			29,219	29,219		29,219	1,629	30,848			33
34	Rent-Facility & Grounds			654,896	654,896		654,896	(654,896)				34
35	Rent-Equipment & Vehicles			4,576	4,576		4,576	6,665	11,241			35
36	Other (specify):*							6,667	6,667			36
37	**TOTAL Ownership**			778,766	778,766		778,766	208,607	987,373			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,634	47,156	128,790		128,790	(233)	128,557			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,247	66,247		66,247		66,247			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		81,634	113,403	195,037		195,037	(233)	194,804			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,901,862	413,876	1,800,555	4,116,293		4,116,293	178,813	4,295,106			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,168	30		9
10	Interest and Other Investment Income	(14,938)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(420)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,830)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,606)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(800)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,331)	20		28
29	Other-Attach Schedule	(30,800)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,557)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	235,370		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 235,370		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 178,813		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

STERLING PAVILION, LTD.

ID# 0040436

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs & Maintenance	$ (2,657)	6	1
2	Trust Fees (Bldg Co.)	(150)	20	2
3	Discounts Earned	(633)	2	3
4	Collection Fees	(417)	21	4
5	Bank Charges	(127)	21	5
6	PPA - Dues & Subscriptions	(184)	20	6
7	PPA - Food	(14)	2	7
8	PPA - Employee Benefits	(18,560)	22	8
9	PPA - Supplies	(110)	10	9
10	PPA - Offfice Expenses	(1,336)	21	10
11	PPA - Travel	(40)	25	11
12	Non-Care Depreciation	(6,572)	30	12
13				13
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,067)											(1,067)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			691									691	5
6	Maintenance	(2,657)		3,581	4,276								5,200	6
7	Other (specify):*			740		312							1,052	7
8	**TOTAL General Services**	(3,724)		5,012	4,276	312							5,876	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(110)							(221)				(331)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training			108									108	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(110)		108					(221)				(223)	16
	C. General Administration													
17	Administrative				130,618								130,618	17
18	Directors Fees													18
19	Professional Services			(188,205)									(188,205)	19
20	Fees, Subscriptions & Promotions	(25,101)	150	945									(24,006)	20
21	Clerical & General Office Expenses	(2,680)		38,460	4,191								39,971	21
22	Employee Benefits & Payroll Taxes	(18,560)											(18,560)	22
23	Inservice Training & Education													23
24	Travel and Seminar			771									771	24
25	Other Admin. Staff Transportation	(40)		98									58	25
26	Insurance-Prop.Liab.Malpractice			3,114									3,114	26
27	Other (specify):*			6,202		14,823							21,025	27
28	**TOTAL General Administration**	(46,381)	150	(138,615)	134,809	14,823							(35,214)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,215)	150	(133,495)	139,085	15,135			(221)				(29,561)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	8,596	179,310	2,930									190,836	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,938)	670,968	1,676									657,706	32
33	Real Estate Taxes			1,629									1,629	33
34	Rent-Facility & Grounds		(654,896)										(654,896)	34
35	Rent-Equipment & Vehicles			6,665									6,665	35
36	Other (specify):*		6,667										6,667	36
37	TOTAL Ownership	(6,342)	202,049	12,900									208,607	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(233)				(233)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers								(233)				(233)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(56,557)	202,199	(120,595)	139,085	15,135			(454)				178,813	45

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Sterling Building Pavilion, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 654,896	Sterling Building Pavilion, LLC		$	$ (654,896)	1
2	V	32	Interest Expense		Sterling Building Pavilion, LLC		670,968	670,968	2
3	V	30	Depreciation		Sterling Building Pavilion, LLC		179,310	179,310	3
4	V	36	Amortization		Sterling Building Pavilion, LLC		6,667	6,667	4
5	V	20	Trust Fees		Sterling Building Pavilion, LLC		150	150	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 654,896			$ 857,095	$ * 202,199	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 691	$ 691	15
16	V	6	REPAIRS & MAINT.				3,581	3,581	16
17	V	7	EMP.BEN. - GEN. SERVICES				740	740	17
18	V	13	NURSES AIDE TRAINING				108	108	18
19	V	19	PROFESSIONAL FEES				1,555	1,555	19
20	V	20	DUES AND SUBSCRIPTIONS				945	945	20
21	V	21	CLERICAL & GENERAL				38,460	38,460	21
22	V	24	SEMINARS AND TRAVEL				771	771	22
23	V	25	ADMIN. STAFF TRANS.				98	98	23
24	V	26	INSURANCE				3,114	3,114	24
25	V	27	EMP.BEN. - GEN. ADMIN.				6,202	6,202	25
26	V	30	DEPRECIATION				2,930	2,930	26
27	V	32	INTEREST				1,676	1,676	27
28	V	33	REAL ESTATE TAXES				1,629	1,629	28
29	V	35	EQUIPMENT RENTAL				6,665	6,665	29
30	V								30
31	V	19	BOOKKEEPING SERVICES	189,760				(189,760)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 189,760			$ 69,165	$ * (120,595)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 4,276	$ 4,276	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				26,522	26,522	17
18	V	17	ADMIN. CMP. - M. AARON				35,820	35,820	18
19	V	17	ADMIN. CMP. - F. AARON				27,690	27,690	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17	ADMIN. CMP. - S. KOPLIN				7,631	7,631	21
22	V	17	ADMIN. CMP. - D. MAGAFAS				8,614	8,614	22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN						24
25	V	17	ADMIN. CMP. - S. LEVY				9,295	9,295	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				15,046	15,046	27
28	V	21	CLERICAL CMP. - S. AARON				4,191	4,191	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 139,085	$ * 139,085	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 312	$ 312	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				1,693	1,693	17
18	V	27	EMP. BEN.- M. AARON				2,470	2,470	18
19	V	27	EMP. BEN.- F. AARON				3,182	3,182	19
20	V	27	EMP. BEN.- S. GOLDSTEIN						20
21	V	27	EMP. BEN.- S. KOPLIN				1,749	1,749	21
22	V	27	EMP. BEN.- D. MAGAFAS				1,854	1,854	22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN						24
25	V	27	EMP. BEN.- S. LEVY				1,290	1,290	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				2,023	2,023	27
28	V	27	EMP. BEN. - S. AARON				562	562	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 15,135	$ * 15,135	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 16,020	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 16,020	$	15
16	V	19	PROFESSIONAL FEES	1,000	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	1,000		16
17	V	22	EMPLOYEE BENEFITS	(4,889)	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	(4,889)		17
18	V	39	ANCILLARY SERVICES	40,939	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	40,939		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,070			$ 53,070	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 6,855	PHARMCOR, L.L.C.	100.00%	$ 6,855	$	15
16	V	19	PROFESSIONAL FEES	50	PHARMCOR, L.L.C.	100.00%	50		16
17	V	21	CLERICAL & GENERAL	56	PHARMCOR, L.L.C.	100.00%	56		17
18	V	22	EMPLOYEE BENEFITS	1,635	PHARMCOR, L.L.C.	100.00%	1,635		18
19	V	39	ANICILLARY EXPENSE	41,436	PHARMCOR, L.L.C.	100.00%	41,436		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,032			$ 50,032	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V	10	MEDICAL SUPPLIES	1,066	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	845	(221)	16
17	V	39	ANCILLARY EXPENSE	1,123	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	890	(233)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,189			$ 1,735	$ * (454)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Maurice Aaron	Owner	Administrative	22.23%	see attached	3.1	6.18%	Sal-Dynamic	$ 35,820	17-7	1
2	Marshall Mauer	Owner	Administrative	8.26%	see attached	2.7	5.32%	Sal-Dynamic	26,522	17-7	2
3	Sue Koplin	Owner	Administrative	0.39%	see attached	4.77	10.60%	Sal-Dynamic	7,631	17-7	3
4	Diania Magafas	Owner	Administrative	0.39%	see attached	4.73	10.52%	Sal-Dynamic	8,614	17-7	4
5	Dennis Nehmer	Owner	Maintenance	0.39%	see attached	2.75	6.87%	Sal-Dynamic	4,276	6-7	5
6	Sharon Aaron	Relative	Clerical		see attached	2.66	6.49%	Sal-Dynamic	4,191	21-7	6
7	Fred Aaron	Owner	Administrative	23.80%	see attached	6.5	14.45%	Sal-Dynamic	27,690	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 114,744		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	577,359	15	$ 10,580	$	37,707	$ 691	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	577,359	15	54,834	37,633	37,707	3,581	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	577,359	15	11,326		37,707	740	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	577,359	15	1,650		37,707	108	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	577,359	15	23,811		37,707	1,555	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	577,359	15	14,469		37,707	945	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	577,359	15	588,891	487,646	37,707	38,460	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	577,359	15	11,803		37,707	771	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	577,359	15	1,502		37,707	98	9
10	26	INSURANCE	PATIENT DAYS	577,359	15	47,685		37,707	3,114	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	577,359	15	94,969		37,707	6,202	11
12	30	DEPRECIATION	PATIENT DAYS	577,359	15	44,866		37,707	2,930	12
13	32	INTEREST	PATIENT DAYS	577,359	15	25,667		37,707	1,676	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	577,359	15	24,936		37,707	1,629	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	577,359	15	102,054		37,707	6,665	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 69,165	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	62,194	62,194	3	4,276	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	45,894	45,894			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	13	398,821	398,821	3	26,522	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	12	521,536	521,536	3	35,820	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,700	191,700	7	27,690	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	161,003	161,003			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	8	71,993	71,993	5	7,631	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	8	81,938	81,938	5	8,614	8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	47,846	47,846			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	96,858	96,858			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	13	139,807	139,807	4	9,295	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	9,000	9,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	13	219,069	219,069	3	15,046	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	13	63,022	63,022	3	4,191	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,683		$ 139,085	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		4,545		3	312	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		3,924				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		25,461		3	1,693	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		35,957		3	2,470	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45		22,028		7	3,182	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		20,193				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		16,504		5	1,749	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		17,632		5	1,854	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38		11,976				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		6,849				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		19,408		4	1,290	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40		1,068				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		29,449		3	2,023	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		8,457		3	562	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 15,135	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						16,020	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						1,000	2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						(4,889)	3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						40,939	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 53,070	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						6,855	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						50	2
3	21	CLERICAL & GENERAL	DIRECT ALLOCATION						56	3
4	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						1,635	4
5	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						41,436	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 50,032	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						845	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						890	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,735	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Sterling Pavilion Bldg LLC	X		Capitalized Lease			$	$ 6,717,360			$ 670,968	1
2	Manufactures Bank		X	Note Payable				29,505				2
3												3
4												4
5												5
	Working Capital											
6	Manufactures Bank		X	Line of Credit				500,000			31,036	6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,246,865			$ 702,004	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(13,262)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,262)	14
15	TOTALS (line 9+line14)						$	$ 7,246,865			$ 688,742	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (14,938)	1
2	Allocation from Dynamic										1,676	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (13,262)	21

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	30,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,848	2
3. Under or (over) accrual (line 2 minus line 1).	$	848	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	30,848	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	29,705	8
	1997	29,954	9
	1998	29,403	10
	1999	28,961	11
	2000	29,219	12

2001 Real Estate Tax Accrual = 2000 Tax Bill (rounded)

Allocation from Dynamic $1629

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STERLING PAVILION, LTD. COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-402-001	Long Term Care Property	$ 28,135.66	$ 28,135.66
2.	11-16-402-013	Long Term Care Property	$ 1,083.30	$ 1,083.30
3.	10-23-404-059-0000	Home Office Allocation	$ 24,139.10	$ 1,576.51
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,358.06	$ 30,795.47

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000 B. General Construction Type: Exterior Brick Frame Steel / Concrete Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 48,888	1
2	Sterling Building LLC			100,000	2
3	TOTALS			$ 148,888	3

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1993	$ 6,052,408	$ 155,190	35	$ 172,926	$ 17,736	$ 1,175,195	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	18,723		20	938	938	8,067	9
10	Various			1994	6,356		20	319	319	2,420	10
11	Various			1995	13,538		20	677	677	4,279	11
12	Various			1996	33,635		20	1,681	(1,681)	8,885	12
13	Various			1997	65,081		20	3,255	3,255	14,383	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		28,971	743		828	85	6,898	68
69	Financial Statement Depreciation			9,000			(9,000)		69
70	TOTAL (lines 4 thru 69)		$ 6,218,712	$ 164,933		$ 180,624	$ 12,329	$ 1,220,127	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,218,712	$ 164,933		$ 180,624	$ 15,691	$ 1,220,127	1
2	LANDSCAPING	1998	3,000		20	150	150	538	2
3	LANDSCAPING	1998	3,000		20	150	150	538	3
4	GENERATOR	1998	1,899		20	95	95	380	4
5	PARKING LOT	1998	7,500		20	375	375	1,438	5
6	VERTICAL BLINDS	1998	926		20	46	46	176	6
7	HANDRAIL	1998	2,134		20	107	107	410	7
8	FLOOR TILES	1998	2,468		20	123	123	461	8
9	FLOOR PATCH	1998	3,173		20	159	159	596	9
10	CONCRETE WALS	1998	3,190		20	160	160	613	10
11	HORN FOR DOOR	1998	912		20	46	46	165	11
12	FLOOR TILES	1998	3,145		20	157	157	576	12
13	CRASHRAIL	1998	180		20	9	9	33	13
14	LANDSCAPING	1998	3,000		20	150	150	525	14
15	LANDSCAPING	1998	983		20	49	49	163	15
16	LANDSCAPING	1998	700		20	35	35	117	16
17	TILES AND CARPETING	1998	8,877		20	444	444	1,554	17
18	SLAB FOR WASHER	1998	2,350		20	118	118	413	18
19	COUNTER TOPS	1998	1,898		20	95	95	325	19
20	DRYWALL	1998	582		20	29	29	99	20
21	FLOOR DRAIN	1998	2,850		20	143	143	501	21
22	HAND & CRASHRAIL	1998	2,545		20	127	127	413	22
23	HAND & CRASHRAIL	1998	2,133		20	107	107	348	23
24	DRYWALL	1998	576		20	29	29	94	24
25	LAMPS & FIXTURES	1998	445		20	22	22	72	25
26	BATHROOM - REMODELIN	1998	2,635		20	132	132	418	26
27	PATIENT SIGNS	1998	3,318		20	166	166	540	27
28	COVE BASE	1998	420		20	21	21	67	28
29	LANDSCAPING	1998	585		20	29	29	89	29
30	PAINT & DECORATING	1998	21,004		20	1,050	1,050	3,150	30
31	CEILING TILES	1999	601		20	30	30	90	31
32	CONCRETE BLOCK WALLS	1999	3,142		20	157	157	471	32
33	WATER TREATMENT SYS	1999	6,890		20	345	345	1,035	33
34	TOTAL (lines 1 thru 33)		$ 6,315,773	$ 164,933		$ 185,479	$ 20,546	$ 1,236,535	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,315,773	$ 164,933		$ 185,479	$ 20,546	$ 1,236,535	1
2	GAS WATER HEATER	1999	8,935		20	447	447	1,341	2
3	DYNALOCK SYSTEM	1999	4,966		20	248	248	723	3
4	PIPES	1999	526		20	13	13	37	4
5	PIPES	1999	1,550		20	78	78	228	5
6	PIPES	1999	198		20	10	10	29	6
7	HANDRAIL	1999	2,393		20	120	120	340	7
8	TILE	1999	135		20	7	7	20	8
9	ACT/NURSE STATION	1999	1,128		20	56	56	159	9
10	ACT/NURSE STATION	1999	1,076		20	54	54	153	10
11	DRYWALL	1999	1,525		20	76	76	203	11
12	AIR CONDITIONER	1999	5,533		20	277	277	716	12
13	CAMERA SYSTEM	1999	2,500		20	125	125	333	13
14	ACT/NURSE STATION	1999	2,500		20	125	125	354	14
15	TILING	1999	3,513		20	176	176	425	15
16	DRAPES	1999	2,117		20	106	106	247	16
17	ACTIVITY ROOM	1999	935		20	47	47	110	17
18	ACTIVITY ROOM REMOD	1999	828		20	41	41	96	18
19	WATER SERVICE	1999	2,469		20	123	123	287	19
20	WATER SERVICE	1999	98		20	5	5	12	20
21	WATER MAIN REPLACE	1999	940		20	47	47	106	21
22	REMODELING	1999	1,154		20	58	58	131	22
23	WATER MAIN INSTALL	1999	238		20	12	12	27	23
24	NURSES STATION	1999	6,244		20	312	312	676	24
25	WALL	1999	801		20	21	21	43	25
26	LANDSCAPING	1999	705		20	35	35	105	26
27	PARKING BLOCKS	1999	1,025		20	51	51	119	27
28	WALLPAPER	1999	885		20	44	44	128	28
29	WALLPAPER	1999	5,367		20	268	268	782	29
30	PAINTING	1999	875		20	44	44	128	30
31	COVE BASE	1999	339		20	17	17	50	31
32	WALLPAPER	1999	880		20	44	44	110	32
33	WALLPAPER	1999	690		20	35	35	85	33
34	TOTAL (lines 1 thru 33)		$ 6,378,841	$ 164,933		$ 188,601	$ 23,668	$ 1,244,838	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,378,841	$ 164,933		$ 188,601	$ 23,668	$ 1,244,838	1
2	WALLPAPER	1999	1,729		20	86	86	215	2
3	GENERATOR	1999	579		20	29	29	87	3
4	OVEN REPAIR	1999	613		20	31	31	88	4
5	FIRE ALARM	1999	560		20	28	28	79	5
6	PLUMBING	1999	595		20	30	30	70	6
7	MIRRORS	2000	481		20	24	24	48	7
8	CUBICLE CURTAINS	2000	1,036		20	52	52	91	8
9	COUNTER TOPS	2000	485		20	24	24	40	9
10	FLOOR TILES	2000	549		20	27	27	45	10
11	DRYWALL	2000	490		20	25	25	42	11
12	INSTALL THERMOSTAT	2000	1,856		20	93	93	140	12
13	NURSE STATION CAMERA	2000	1,975		20	99	99	140	13
14	DRYWALL	2000	862		20	43	43	61	14
15	FREEZER DOOR & FRAME	2000	1,153		20	58	58	63	15
16	PAINTING & DECORATING	2000	3,035		20	152	152	228	16
17	CARPETING	2001	934		20	47	47	47	17
18	TILE	2001	558		20	28	28	28	18
19	SPRINKLER SYSTEM REP	2001	2,002		20	75	75	75	19
20	DYNA LOCKS	2001	5,085		20	169	169	169	20
21	OVERBED LIGHT	2001	1,098		20	37	37	37	21
22	EMERGENCY LIGHTS	2001	365		20	12	12	12	22
23	SMOKE DETECTORS	2001	1,083		20	36	36	36	23
24	PARKING CURB	2001	1,023		20	30	30	30	24
25	DOOR	2001	1,133		20	29	29	29	25
26	CEILING TILE INSTALL	2001	1,035		20	26	26	26	26
27	SEALER FOR PARKING L	2001	445		20	11	11	11	27
28	FENCE	2001	292		20	8	8	8	28
29	PARKING LOT PAINTING	2001	785		20	23	23	23	29
30	REPAIR WALLS	2001	1,285		20	27	27	27	30
31	DOORS	2001	527		20	9	9	9	31
32	CIRCUIT BRD-DYNALOC	2001	1,170		20	10	10	10	32
33	TELE. SYS.-TRI-CITY	2001	9,890		20	330	330	330	33
34	TOTAL (lines 1 thru 33)		$ 6,423,549	$ 164,933		$ 190,309	$ 25,376	$ 1,247,182	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,423,549	$ 164,933		$ 190,309	$ 25,376	$ 1,247,182	1
2	SHOP SINK BASINS	2001	969		20	8	8	8	2
3	SHOP SINK BASINS	2001	420		20	4	4	4	3
4	SHOP SINK BASINS	2001	515		20	2	2	2	4
5	PLUMBING	2001	532		20	27	27	27	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,425,985	$ 164,933		$ 190,350	$ 25,417	$ 1,247,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 28,971	$ 743	35	$ 828	$ 85	$ 6,898	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 28,971	$ 743		$ 828	$ 85	$ 6,898	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 250,827	$ 37,441	$ 24,897	$ (12,544)	10	$ 110,692	71
72	Current Year Purchases	10,598	45	782	737	10	782	72
73	Fully Depreciated Assets	363,000	17,548	17,548		10	363,000	73
74								74
75	TOTALS	$ 624,425	$ 55,034	$ 43,227	$ (11,807)		$ 474,474	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Business	BUS	2000	$ 45,441	$ 14,541	$ 15,147	$ 606	5	$ 26,507	76
77	Allocation from Dynamic		2001	3,677	200	1,152	952	5	1,152	77
78										78
79										79
80	TOTALS			$ 49,118	$ 14,741	$ 16,299	$ 1,558		$ 27,659	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,248,416	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 234,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 249,876	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,168	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,749,356	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section 754 Adj - Land - 2000	$ 4,235	$	$	86
87	Section 754 Adj - Building - 2000	256,308	6,572	7,394	87
88					88
89					89
90					90
91	TOTALS	$ 260,543	$ 6,572	$ 7,394	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 11,241 Description: Copier $2580, Ice Machine $1620, Saws & Drills $376, allocation from Dynamic $6665
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,490	$	$ 1,490
2	Books and Supplies		250		250
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				ALLOC.
7	Contractual Payments				DYNAMIC
8	Nurse Aide Competency Tests		108		108
9	TOTALS	$	$ 1,848	$	$ 1,848
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,848			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 13,814	$		$ 13,814	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,291			6,291	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			27,051			27,051	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				68,615		68,615	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						13,019		13,019	13
14	TOTAL			$		$ 47,156	$ 81,634		$ 128,790	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (81,833)	$ (81,833)	1
2	Cash-Patient Deposits	9,901	9,901	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	736,236	736,236	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,517	34,517	6
7	Other Prepaid Expenses	2,902	2,902	7
8	Accounts Receivable (owners or related parties)	200,000	200,017	8
9	Other(specify): See supplemental schedule	28,892	40,992	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 930,615	$ 942,732	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,235	13
14	Buildings, at Historical Cost		6,308,716	14
15	Leasehold Improvements, at Historical Cost	334,785	334,785	15
16	Equipment, at Historical Cost	298,777	661,777	16
17	Accumulated Depreciation (book methods)	(250,248)	(1,778,101)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	244,990	65,087	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 628,304	$ 5,696,499	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,558,919	$ 6,639,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 110,464	$ 110,464	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,901	9,901	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	176,800	176,800	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,882	2,882	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,000	30,000	32
33	Accrued Interest Payable	2,208	2,208	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,440	6,440	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 338,695	$ 338,695	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	529,505	529,505	39
40	Mortgage Payable		6,717,360	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 529,505	$ 7,246,865	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 868,200	$ 7,585,560	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 690,719	$ (946,329)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,558,919	$ 6,639,231	48

*(See instructions.)

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 807,390	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 807,390	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(13,821)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(102,850)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (116,671)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 690,719	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,001,995	1
2	Discounts and Allowances for all Levels	(483,441)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,518,554	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	436,910	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 436,910	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,924	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,959	19
20	Radiology and X-Ray	8,122	20
21	Other Medical Services	16,432	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,437	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,938	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,938	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	633	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 633	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,102,472	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	769,076	31
32	Health Care	1,541,108	32
33	General Administration	832,306	33
	B. Capital Expense		
34	Ownership	778,766	34
	C. Ancillary Expense		
35	Special Cost Centers	128,790	35
36	Provider Participation Fee	66,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,116,293	40
41	**Income before Income Taxes (line 30 minus line 40)****	(13,821)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (13,821)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,759	1,783	$ 46,576	$ 26.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,860	10,484	201,362	19.21	3
4	Licensed Practical Nurses	19,021	20,747	311,061	14.99	4
5	Nurse Aides & Orderlies	69,324	73,741	683,437	9.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,140	3,349	83,635	24.97	8
9	Activity Director	1,304	1,472	17,395	11.82	9
10	Activity Assistants	4,827	5,213	37,941	7.28	10
11	Social Service Workers	3,426	3,650	39,448	10.81	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,160	23,162	10.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,378	19,144	124,229	6.49	15
16	Dishwashers					16
17	Maintenance Workers	4,333	4,453	49,655	11.15	17
18	Housekeepers	12,749	14,509	106,917	7.37	18
19	Laundry	7,089	7,580	50,184	6.62	19
20	Administrator	1,944	2,160	74,400	34.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,789	4,075	38,914	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,824	1,917	13,546	7.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,775	176,437	$ 1,901,862 *	$ 10.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	168	$ 7,080	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	51	1,640	10-03	38
39	Pharmacist Consultant	121	3,931	10-03	39
40	Physical Therapy Consultant	392	12,200	10a-03	40
41	Occupational Therapy Consultant	96	3,820	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	93	5,315	12-03	45
46	Other(specify)				46
47	Nurse Consult. - Dart Chart	monthy	10,944	10-03	47
48	Food Purchasing Agent	monthy	1,000	01-03	48
49	TOTAL (lines 35 - 48)	921	$ 45,930		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Reed	Administrator	0	$ 74,400
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,400

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 3,618
Econocare Inc.	Purchasing Services	2,178
Personnel Planners	Unemployment Consult	2,855
Frost Ruttenberg & Rothblatt	Accounting	20,497
Sachnoff & Weaver, LTD	Legal	4,509
Littler Medelson, P.C	Legal	146
Reduction of current year legal fees for prior year expense		(391)
Dynamic Heathcare	Bookkeeping Services	189,760
Dynamic Rehab	Professional Fees	1,000
Pharm-Cor	Professional Fees	50
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 224,222

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,337
Unemployment Compensation Insurance	20,206
FICA Taxes	143,412
Employee Health Insurance	102,796
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,082
TOTAL (agree to Schedule V, line 22, col.8)	$ 312,833

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,177
Health Care Worker Background Check	315
(Indicate # of checks performed 45)	
Dues & Subscriptions	687
Licenses & Permits	1,475
Advertising & Promotion	18,606
Yellow Page Advertising	2,331
Allocation from Dynamic	945
Less: Public Relations Expense	
Non-allowable advertising	(18,606)
Yellow page advertising	(2,331)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,599

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,192
Allocation from Dynamic	771
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,963

**See instructions.

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number STERLING PAVILION, LTD. # 0040436 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,250** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,247**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees